Report to Banking Commerce and Insurance Committee on PCMH
LB 239, Tuesday Feb 12, 2013

Outline of Testimony of Margaret Kohl, Legislative Aide for Senator Mike Gloor

To give you a little history on the work that has been done on Patient centered medical home in Nebraska.

1. NMA brought in speakers and started the discussion

2. Senator Gloor, LB 396 in 2009
    Medicaid Medical Home Pilots
    pilot program ran from Jan. 2011 to Dec 2012 – 2 years
    Advisory Council - 6 primary care doctors, 1 hosp rep and Sen. Gloor
    over 50 staffers in HHS worked on details of IT and oversight
    I was included in 2 subcommittees that drew up the standards and evalution

    Two clinics, Plum Creek in Lexington and Kearney Clinic in Kearney
    avg # of patients per month in pilot – 7,308

    Upfront costs paid for by Medicaid included:
        Per member per month fees – explain
        care coordinator
        technical assistance from TransforMed that helped clinics redefine
            administrative procedures, start population management, quality
            improvement and leadership in change
        disease registry (component of EHR)
    Evaluation phase with a report due by June 1, 2014.

3. What did the $730,000 Upfront costs pay for?
    Example: The care coordinator from Kearney reported that she is providing weekly monitoring of diabetic patients between physician visits and medication assistance to help patients maintain control of their diabetes. The care coordinator at Plum Creek reported they now use Asthma Action Plans and a tool kit to help asthma patients understand and follow treatment plans. All with the goal of improving patient health and preventing unnecessary future medical expenses.

** This upfront cost needs to be borne by all the payers in the system. The clinics in the Medicaid pilot program had to completely redesign how they provided care to all their patients, not just their Medicaid patients. All their patients, even the ones with private

insurance, benefit from the use of PCMH so it's a matter of fairness in a competitive market. Plus the upfront costs need to be covered in order to make the new system sustainable.

4. NE Medicaid is moving ahead with PCMH despite still being in the evaluation phase of the original pilot - managed care companies (3) required by contract to build 2+ PCMH pilots per year

5. *Health care professionals* across NE are becoming certified by national organization such as NCQA (National Commission on Quality Assurance). Some *insurance* companies are moving toward PCMH but none are completely there yet.

6. At National level - Medicare has proceeded with a national pilot program that continues to expand and will participate with any state that has a multi-payer PCMH. Started with 8 states, expanded to 16 now it's all states.

7. Locally work continues with LR 513 working group
   - Senator Wightman's study resolution created stakeholder group – totally voluntary
   - Have tentative agreement on adult clinical measures and standards. They are working on pediatric and obstetric clinical measures
   - Next steps are tougher – a common reimbursement structure, implementation

8. NASHP grant
   - National Academy of State Health Policy
   - 18 month technical assistance grant to help states overcome barriers in creating multi-payer
   - Kick off meeting for that will be April 4 and 5

9. Fiscal note – Sen. G has talked with DOI, Roger and I have talked with DOI. Because DOI was not familiar with the pilot projects and the work already in progress by the LR 513 working group, they thought they would have to start from scratch, hire experts, etc – thus the large fiscal note. When they found out all the work that has already been done, they agreed the fiscal note was high and we could revise it going forward.

10. LB 239 is moving in the right direction.

Gloor question: What do you expect to gain from participation in the new grant and how will it further the work of the LR 513 working group?

Guidance on :

NASHP has information about how other states have created PCMH and they have access to the experts. Our lead team for the grant (me, Rauner, Tonniges, Esser) will be the conduit for information from the grant activity to the LR 513 working group and the whole group will make decisions on what steps to take to figure out how to do this in our state. When we participate in webinars or bring experts to the state, the entire working group will be included.

Issues:
anti-trust issues
patient attribution methods
market and contract issues
information on various payment structures
getting participation from all sectors
what's happening on the federal level that we need to incorporate
Timing – we are already missing out on the Medicare participation
Ultimately, what would work best in Nebraska for multi-payer PCMH to create a sustainable structure that will meet the goals of better health care at less cost